

Manuscript Number: SSM-D-13-01564R1

Manuscript Title: Sites of institutional racism in public health policy making in New Zealand

Order of Authors:

Dr Heather Came

Auckland Univeristy of Technology

Corresponding author:

Dr Heather Came

heather.came@aut.ac.nz

Department of Public Health

Auckland University of Technology

Private Bag 92006

Auckland

New Zealand

Acknowledgment/s:

Thanks to the multiplicity of people who contributed and supported this research project with special mention to Maria Humphries and my research whānau. Thanks also to Jane Koziol-McLain, Don Lemieux, Amy Zander, Tim McCreanor, Kate Diesfeld and Shoba Nayar for their comments and feedback on this paper.

Key words: Institutional racism, health policy, Treaty of Waitangi, critical race theory, New Zealand

Sites of institutional racism in public health policy making in New Zealand

Abstract

Although New Zealanders have historically prided ourselves on being a country where everyone has a 'fair go', the systemic and longstanding existence of health inequities between Māori and non-Māori suggests something isn't working. This paper informed by critical race theory, asks the reader to consider the counter narrative viewpoints of Māori health leaders; that suggest institutional racism has permeated public health policy making in New Zealand and is a contributor to health inequities alongside colonisation and uneven access to the determinants of health. Using a mixed methods approach and critical anti-racism scholarship this paper identifies five specific sites of institutional racism. These sites are: majoritarian decision making, the misuse of evidence, deficiencies in both cultural competencies and consultation processes and the impact of Crown filters. These findings suggest the failure of quality assurance systems, existing anti-racism initiatives and health sector leadership to detect and eliminate racism. The author calls for institutional racism to be urgently addressed

within New Zealand and this paper serves as a reminder to policy makers operating within other colonial contexts to be vigilant for such racism.

Introduction

The New Zealand government, as part of its obligations to the international community, is bound by a range of legislative and human right imperatives to ensure all New Zealanders can enact their right to health (United Nations, 1948, 1976, 2007). These obligations are enabled by a range of domestic controls (see Palmer, G & Palmer M, 2004) and are underpinned by a foundational commitment to Māori (the indigenous peoples of New Zealand) as outlined in Te Tiriti o Waitangi. Te Tiriti was negotiated between hapū (sub tribes) and the British Crown. It reaffirmed Māori sovereignty, established the terms and conditions of British governance and subsequent settlement and granted Māori equal citizenship rights with the British. Durie (1989) maintains Te Tiriti also specifically protects Māori health as a taonga (treasure) under article two. Despite these obligations and other initiatives that could broadly be described as ‘anti-racist’ (Human Rights Commission, 2011), health researchers continue to track chronic health inequities across a multiplicity of health outcomes, including a 7.3 year disparity in life expectancy between Māori and non-Māori (Ministry of Social Development, 2010; Statistics New Zealand, 2013). The author notes the ordinary delivery of services to Māori as part of the overall population does not qualify as an anti-racism intervention.

The Ministry of Health and its earlier manifestations have been responsible for the co-ordination and strategic direction of New Zealand's health sector since 1900. Its core mission has been to oversee the provision of clinical services and to protect and promote health (Dow, 1995). The legislation covering the health system requires Crown agencies to prioritise reducing health inequities and engage with the Crown-defined principles of the Treaty of Waitangi (Royal Commission on Social Policy, 1988). The Ministry of Health and regional District Health Boards (DHBs) hold responsibility for drafting and overseeing health policy.

There are competing and complimentary discourses in relation to probable causes and solutions to New Zealand's systemic health inequities. These discourses often draw on neoliberal mantras of personal responsibility (Ryall, 2007) and cultural deficit theory (Reid & Robson, 2007). Being mindful that the Ministry of Health has recognized institutional racism as a determinant of health in policy documents since the 1990s this paper contributes to the debate by using counter narratives to identify specifically how institutional racism manifests within the public health system and how it might be transformed. This paper leaves open the opportunity for other scholars to offer an alternative analysis to the phenomenon described as institutional racism within this paper. The author cautions the presence of good intentions does not neutralise racism and that lack of capacity, time and resource are not considered by international human rights bodies as credible justifications for the presence of racism. Public health within this paper refers to population based interventions to enable people to increase control over the factors that determine their health, not the provision of clinical services.

Institutional racism against Māori was first exposed within the administration of the public sector in the 1980s (Berridge et al., 1984; Jackson, 1988). The landmark report Pua Te Ata Tu (Ministerial Advisory Committee on a Māori Perspective on Social Welfare, 1988, p. 19) described institutional racism as:

...the outcomes of mono-cultural institutions which simply ignore and freeze out the cultures of those who do not belong to the majority. National structures are evolved

which are rooted in the values, systems and viewpoints of one culture only. Participation by minorities is conditional on their subjugating their own values and systems to those of “the system” of the power culture.

This paper is part of a wider study (Came, 2013), that revisits this earlier work, examining how institutional racism manifests in public health policy making and funding practice. The study emerged out of dialogue with Māori concerned about the health system failing to meet the needs of Māori. Many named these failings as breaches of Te Tiriti o Waitangi, or as institutional racism. Their claims are affirmed in 89 deeds of claims logged with the Waitangi Tribunal (an independent commission of inquiry into alleged breaches of Te Tiriti) in relation to the Crowns’ historic and contemporary administration of the health sector (Crown official cited in Came, 2013,18).

Institutional racism within the context of this research, informed by the writings of Paradies (2005) and Jones (2000), refers to: “...a pattern of differential access to material resources and power determined by race, [which] advantages one sector of the population while disadvantaging another” (Came, 2013, i). Such racism encompasses both action and inaction and can present as systemic mono-cultural perspectives.

The development of health policy is a complex and inherently political process of managing diverse interests in an ever-changing political environment (Gauld, 2009). Moewaka Barnes (2013) argues within the New Zealand context decisionist, technocratic and co-production based models of policy development are all utilised within health policy. The broad parameters remain constant but each policy process is unique depending on the political climate at the time and the policy actors involved. Carroll et al. (2008) has isolated a range of factors that influence policy, including statistics, expert views, personal experience, cultural knowledge, party ideology, public perception and political expediency. It seems reasonable to assume all involved set out with the intention to develop policy that will improve health outcomes but the realities of competing priorities and limited capacity can compromise quality (Nunns, 2009). This paper explores critical points within the policy cycle where institutional racism can be identified.

Methodology and Method

From a methodological perspective this work was informed by kaupapa Māori theory (Smith, 2012) and the emerging fields of activist scholarship (Sudbury & Okazawa-Rey, 2009) and critical race theory (Ford & Airhihenbuwa, 2010). This orientation makes both the research process and the research outcomes equally important in assessing the contribution of this work. The research was shaped and guided by a predominately Māori research whānau (family) who served as a governance structure for the research, and acted as political and cultural kaitiaki (guardians). The author is a seventh generation Pākehā (settler) New Zealander with a background in public health, and anti-racism activism. This paper assumes the existence of institutional racism and is written as a contribution to collective efforts to describe and end institutional racism. Ethical approval for the study design was secured through the University of Waikato Management School. The author also explored ethical and process issues arising from this work through the application of the Te Ara Tika Māori ethical framework (Hudson et al., 2010) which is examined in a separate paper (Came, 2013). The research was supported via a University of Waikato Doctoral Scholarship.

The study utilised a mixed method approach, applying what Gillborn (2006) describes as master and counter narratives and was carried out in New Zealand. Master narratives are the

dominant viewpoints of the powerful, in this instance, the perspective of the Crown. Counter narratives are the often missing minority perspectives in this study, represented by first-person accounts from Māori health leaders. In focusing on counter narratives within this paper, rigor is established through the use of multiple sites of data collection to inform analysis rather than a more positivist approach of investigating alternative explanations (or justifications) of Crown behaviour.

Master policy narratives were compiled through a document review of Ministry of Health policy documents from 1999 to 2011. This covered the period of the Labour-led government (1999-2008) and the beginnings of the National-led government (2008-2011). This review included core documents, such as the New Zealand Health Strategy (King, 2000), He Korowai Oranga (King & Turia, 2002), Achieving Health for All (Ministry of Health, 2003a), Better, Sooner, More Convenient (Ryall, 2007), Meeting the Challenge (Ministerial Review Committee, 2009) and Whānau Ora (Whānau Ora Taskforce, 2009); as well as nineteen meso level policy documents. These documents were examined in relation to their methodology, inclusion of Māori worldviews and citations of Māori academics. Given health policy is signed off by Crown Ministers and senior Crown officials this document review served as a proxy for the Crowns' official record - their master narrative(s) - within the study. This analysis was supplemented with a semi-structured interview, conducted with an upper echelon Crown official, to confirm operational practice. The scope of this interview did not include an opportunity to share the initial research findings.

Responding to Jackson's (2000) claims that indigenous perceptions of government are shaped by historical experiences, the foundation of the counter narrative within this study was a historical analysis of state racism. This analysis was refreshed through counter narratives generated through a method Bishop (1996) describes as collaborative storytelling with nine senior Māori leaders and a Pākehā crone (feminist leader). Storytellers were recruited from the research whānau and authors existing networks. They were selected due to their expertise, mana (reputation) and depth of analysis from witnessing Crown practice from various (insider and outsider) vantage points over decades. Many expressed frustration at the marginalization of Māori viewpoints and chose to be identified within the study, in order to tautoko (support) the kaupapa (purpose) of the study. Some storytelling sessions took a number of hours, others occurred in parts over several days. The author led the story telling processes, which took place from September 2010 through to July 2011 and ensured all had the opportunity to amend their transcripts prior to publication.

Data was collected until clear themes and patterns appeared across the stories, exposing five distinct sites of racism. In the traditions of critical race theory, relevant literature and other supporting data was woven through to contextualize these sites of racism. Other data included the author's reflective observational field notes of witnessing racism from January 2009 through to April 2010, while working in an iwi governed organisation. The identified sites of racism were reviewed and finalised in dialogue with the research whānau.

Research findings

The policy-related sites of racism identified through this study were: decision making practices, (mis)use of evidence, deficiencies in both cultural competencies and consultation and the impact of Crown filters.

Decision making practices

Democracy, and more particularly majoritarian decision-making, is often upheld as the epitome of fairness, as this type of decision making reflects the viewpoints of the majority of people (Verba, 2006). This seems reasonable to many within the dominant population. However, for an indigenous minority such a system can be a structural impediment to getting indigenous priorities on the agenda. Political commentator O'Sullivan (2003) asserts when indigenous peoples become a minority in their own country, the imposition of majoritarian democracy and decision making becomes a culturally specific manifestation of historic racism. John Stuart Mill (2006/1859) described this tension in a more global context as 'the tyranny of the majority'.

Across the New Zealand public sector only 8.3% of senior managers are Māori (State Services Commission, 2010). For DHBs at governance level there is a legislative requirement for a minimum of two Māori board members (Gauld, 2003). The effect for Māori of being a structural minority within health decision making is elucidated in the following narratives that demonstrate some of the structural challenges facing Māori. Bergan (cited in Came, 2013, 288-289) recalls time within a Crown management team:

I am the only Māori sitting around the table and there are ten of us. We are sitting up and arguing the prioritisation framework and I am arguing strongly that Māori health should be right up near the top because of poor Māori health outcomes. So we have the debate... you put it on the table, you go hard for it and in the end... if you don't have the numbers, that is where the funding goes.

Counter storyteller, Māori Policy Analyst (cited in Came, 2013, 289) recounts:

I walk into the room and there is me and [my Māori colleague] and then the doctors come in and they are all Pākehā and then you have the CEO [who] is Pākehā, and the population strategist is Pākehā, and the cancer control people who are Pākehā, community groups who are Pākehā. And you know how the hell are we going to make a difference if all the people sitting around the table or the majority of the people sitting around the table making decisions about Māori health are Pākehā and so [my Māori colleague] and I would battle for a Māori voice to be heard, yet that would still be side-lined by the chair who was facilitating the discussion.

Although support for indigenous issues does not necessarily follow ethnic lines, holding a minority view within the context of Crown agencies can be burdensome and intimidating, requiring ongoing explanations and advocacy. Ramsden (1994, 4) from her work implementing cultural safety within the health sector maintains: "...it is not normal for any group in control to relinquish power and resources to the less powerful simply on the grounds of goodwill or a sense of moral obligation". She maintains that the dominant group, in this instance Pākehā, tends to consciously and unconsciously fight to maintain power.

I suggest the outcome of these decision-making practices is reflected in the low priority and visibility of Māori public health within core policy documents (see Ministerial Review Committee, 2009; Ryall, 2007) and low-levels of investment (Came, 2013). A justification for this silence being that Māori health is broadly addressed through the Whānau Ora strategy (Whānau Ora Taskforce, 2010). This said, as of late-2013, public health, secondary and tertiary health services all continue to operate outside the korowai (cloak) of whānau ora policy and funding.

(Mis)use of evidence

After policy makers identify and prioritize an issue, they set out to frame the problem and review evidence. Borell et al (2009) contends problem framing is inherently political, as how problems are seen preclude some and privilege other solutions. A default dominant ontological standpoint, reinforced through power imbalances, can determine the shape and content of policy. Moewaka Barnes (2006, 1) asserts Crown institutions are not culturally neutral in their appraisal of evidence, while Durie (2005) argues within the dominant knowledge system the validity of indigenous knowledge's is questionable. Gluckman (2011) warns policy developed in isolation from a robust review of evidence may be either ineffective or result in adverse outcomes.

The document review of ten years of public health policies for this study, confirmed the predominance of bio-medical constructions of health within policy and the use of epidemiological analysis as the primary platform of health policy in New Zealand. Policy was consistently based on international (and some local) evidence of 'best' practice. Best practice in this context being approaches that are likely to get the strong health outcomes for the majority of the population. Unfortunately, many international studies, particularly from Europe, are based on studies which simply do not assess the effectiveness of public health interventions for indigenous people which restrict their usefulness in a New Zealand context. Humpage (2005) concurs, arguing the recognition of the cultural and political specificity of indigenous peoples is central to strengthening policy.

The tension around international best practice plays out clearly within tobacco policy. Globally Māori have amongst the highest tobacco usage in the world (Ministry of Health, 2011), which is reflected in high cancer rates and is likely to be a major contributor to the life expectancy gap. In response to this, aukati kaipaipa (Dowden & Taite, 2001), (a Māori tobacco cessation programme) was developed which has produced high Māori quit rates. Māori have also instigated a successful tupeka kore tobacco resistance movement (Waa, 2012) to mobilize Māori whānau, hapū and iwi (tribes) to eradicate tobacco. According to Bradbrook (cited in Came, 2013, 296), indigenous evidence of what works within the New Zealand context does not seem to inform tobacco policy. Rather, he maintains policy makers follow what is the global mantra of the day, which is currently securing quit attempts. There is limited or no evidence yet, he suggests, that this approach works for Māori.

A significant body of work documents Māori public health traditions (Lange, 1999; Ratima, 2001) based on Māori understanding of the holistic nature of hauora (health). Te Whare Tapa Whā (Durie, 1994) is one of the most widely cited Māori health models, acknowledging te taha tinana (physical), te taha wairua (spiritual), te taha hinengaro (emotional/mental) and te taha whānau (family) as equally critical elements of health. Māori academics have consistently generated written evidence of what initiatives are effective within Māori communities since the early twentieth century (Pōmare, 1980; Pōmare et al., 1995; Pōmare, 1908; Robson & Harris, 2007). Likewise the growing body of work detailing Māori specific measures of health outcomes has not yet been integrated into health policy (Te Kingi, 2002).

These contributions to health knowledge are showcased within academic journals, books and conference proceedings including the annual Hui Whakapiriripiri (a key Māori health research forum) organised by the Health Research Council. In reviewing health policy from 1999-2011, the work of six Māori health academics and three research institutes were cited in Ministry policy documents. The overwhelming majority of these citations refer to a single

text, Mason Durie's (1994) *Whaiora*. It appears the process used by Crown officials to filter what evidence informs policy consistently minimizes the input of Māori academics. This marginalization is reinforced by relying on international experts to peer review policy, rather than securing indigenous reviewers.

Deficiencies in cultural (and political) competency

Cultural competence involves awareness of one's own cultural idiosyncrasies and, Durie (2001, November) argues the capacity to recognize a range of ethnic viewpoints and value systems and apply them within ones' practice. Political competence in relation to anti-racism praxis is having a base level understanding of social justice issues, and within the New Zealand context, understanding of both colonial history and application of Te Tiriti o Waitangi (Came & da Silva, 2011). It is about being able to fracture (dominant) mono-cultural perspectives, recognize power imbalances and adjust one's practice accordingly. Huygens (2011) maintains decolonisation is often a necessary process for dominant cultural groups to go through to become effective at working with indigenous people. While these cultural and political competencies are a core requirement for public health practitioners (Public Health Association, 2007), Crown policy makers and senior managers have no such professional requirements (State Services Commission, 2007).

A Senior Māori Health Advisor (cited in Came, 2013, 300) suggests mono-culturalism is about Crown officials consciously or unconsciously working from a dominant western set of values and making this the default norm that everything else is measured against; it is about making Māori 'other'. Kuraia (cited in Came, 2013, 300) maintains this dominant cultural mind-set is often overlaid with the unspoken assumptions/undertone that "Māori aren't as good as Pākehā". This prejudice, she suggests, is often implicit within health policy. Berghan (cited in Came, 2013, 301) explains:

...these [Crown officials] are good people... they are benignly incompetent... [they] don't take into account other values; it is kinda like the universality of western values... and that tends to happen through most of the policy processes... they don't see the need to be competent because why should they?... it is the others that need to understand. When in Rome do as Romans do, so when in New Zealand do as Pākehā do; it is that kinda stuff.

Delving deeper, this mono-culturalism also appears to be reflected in human resource systems. Da Silva (cited in Came, 2013, 301) asserts Crown agencies are largely run by people from a dominant [Pākehā] cultural view who employ people with similar views. From her thirty years teaching Te Tiriti o Waitangi within the health sector, anecdotally she notes senior managers and policy makers rarely participate in such training. Thus, she speculates, a self-perpetuating cycle is established, whereby nobody notices what is missing within the framing and content of policy, that is, mono-culturalism is normalized. Da Silva's concerns are historically affirmed in the earlier mentioned reports about the administration of the public sector. These reports raised concerns about racism within recruitment practices and exposed inadequacies in professional development programs

Flawed consultation practices

Having completed the initial policy framing up usually a Crown-led reference or advisory group is then established to populate the policy. These groups are composed of technical experts and other key stakeholders. Participation in these processes allows providers access to information, it can strengthen relationships with decision makers and it enables participants

to assert influence over policy directions. In Came's (2013) survey of public health providers; they were asked how often they were invited to be part of Crown advisory groups. Senior managers from Public Health Units, Non-Governmental Organisations, and Primary Healthcare Organisations were considerably more likely to report 'often' or 'constantly' being invited to serve on advisory groups (42%, 42%, and 35% respectively) compared to Māori Health Providers (14%). When asked about how membership of advisory groups was selected, a Senior Crown Official (cited in Came, 2013, 332) confirmed the process of securing membership in Ministry-led groups was "highly arbitrary". This absence of process enables Māori exclusion.

Consultation is used to test assumptions and secure both additional technical information and fresh perspectives on how to approach and address problems. Both the Ministry of Health and DHBs have statutory obligations to consult with communities (and more specifically Māori) in relation to strategic planning and policy development (Ministry of Health, 2002; Treasury, 2009). However, research by Te Puni Kōkiri (2000) expressed concerns about the ability of Crown agencies to effectively assess Māori needs and aspirations, and they note the limitations of internal consultation. One Māori Provider CEO (cited in Came, 2013, 307) summarized his thirty plus years in the sector with the comment, "I applaud the ones that come out and ask questions...[but] somehow it tends to get lost as they go to write". Others reported a plethora of problems surrounding Crown consultation processes. These included concerns such processes often had too short of a timeframe to easily enable participation. There was also unease expressed at the often narrow scope and framing of questions which was felt to solicit feedback that reinforced dominant paradigms.

Consultation with the public health sector is often managed without engaging with Māori health leaders as often mandated by hapū and iwi. An example of this being the Ministry of Health's 2010 review of the public health service specifications (Ministry of Health, n.d.). This consultation focused singularly on DHBs and PHUs excluding Māori health providers (Came, 2013, 309). At a fundamental level, counter storyteller, Shortland (cited in Came, 2013, 308) explains, Crown officials are "just not listening" they don't understand what is happening on the ground. In her twenty years' experience she suggests Crown-led policy often has incorrect information and there is a lack of accountability to communities. This position is reinforced in historic evidence that suggests many of the key recommendations from the landmark Māori health hui (forums) (Department of Health, 1984, March; Dyll, 1994) from the 1980s and 1990s remain unaddressed.

Impact of Crown filters

"Crown filters" is a term coined by Berghan (cited in Came, 2013, 311) to describe how Crown officials manage the policy development process and navigate its sign-off. Crown filters are visible throughout the drafting of policy and be most prominent in the final policy steps. Berghan asserts, depending on the racial climate, Crown filters often serve to dilute Māori content in policy. From his thirty years in the sector, he observes decision making is not always based on evidence, but rather the dominant political ideology of the day and risk management. To illustrate this, Berghan cites his involvement with the development of Raranga Tupuake (Ministry of Health, 2006b) Māori workforce development strategy. The strategy document he explains (cited in Came, 2013, 311) went through seventeen iterations and initially it was a wonderful piece of work developed by experienced people. However once it had passed through the Crown filters,

... it missed out a whole lot of the key stuff we [Māori] wanted, which they [Crown officials] saw as being problematic, because it came out at the same time as... Don Brash was doing his stuff and Helen Clarke was getting very sensitive around Māori politics... it is the perfect illustration of the stuff that Māori go through, which does not have institutional racism written across it but actually when you delve down and look through it all, and across all the hoops, it is a classic example of what goes on... it has affected our ability to develop the Māori health workforce (p311).

A more recent example under the National-led government is the Whānau Ora Taskforce, which was mandated to work across government to develop an evidence-based framework for a preferred approach to deliver services to Māori whānau. Under the leadership of Sir Mason Durie, the taskforce (Whānau Ora Taskforce, 2010) affirmed a kaupapa Māori approach based on the principle of ngā kaupapa tuku iho. This principle describes how whānau are part of a wider system in Māori epistemology, driven by intergenerational transmission of knowledge, culture, reciprocity and resources. Upon the report's release, the Prime Minister, John Key, reframed the policy to be inclusive of all families in need, which redefined a key philosophy of that platform (Wright, 2010, February 15).

Other reports of Crown filters from this study reflect a relentless and profound ideological struggle within health policy. Kuraia (cited in Came, 2013, 304-5) explains her experiences of engaging in policy with Crown officials:

The input we were providing would be written out, it would be ignored, it would be twisted, it would be reframed, we would reframe it back again into what it was supposed to be and then it would be left out entirely. And when we challenged it, when we questioned it, excuses usually came in the form of "oh we were under time pressure to get this produced because the CEO wanted it published" or some such thing. Basically they'd say "we ran out of time so just couldn't put your stuff in".

Discussion

This study identified sites of racism across the policy making processes despite a raft of controls across the system to prevent discrimination. Racism was detected within decision making process and within the (mis)handling of evidence that informs policy. These systemic biases are complicated by deficiencies in cultural and political competencies and consultation processes. The claims within this paper echo and amplify earlier reports on racism within the public sector as well as within health-related Waitangi Tribunal deeds of claims. It seems this pattern of behavior has survived changes in government and can be tracked across successive race relations policy platforms whether it be colonisation, assimilation, biculturalism or neo-liberalism (O'Sullivan, 2007).

The cumulative effect of these sites of racism is the development of mono-cultural health policy which marginalizes Māori perspectives and paradigms within health policy. To see this systemic racism one needs to look beyond the detail of individual sites of racism, to witness the pattern of Crown behavior against Māori. These identified sites of racism are all modifiable so are opportunities for potential anti-racism interventions. The success of interventions will depend on the political commitments of Crown Minister(s) and Crown officials (and ultimately the sector) to address structural discrimination. The following section offers some preliminary direction for anti-racism interventions.

Anti-racism pathways

In the first instance to address institutional racism at its origins, New Zealand as a society needs to continue to engage with decolonisation processes, honor Te Tiriti o Waitangi and enable the restoration of hapū sovereignty to address power imbalances. Given institutional racism is a complex problem it lends itself well to a multi-level systems change intervention (Griffith et al., 2007). This would integrate well with quality improvement paradigms (Ministry of Health, 2003b) already used within the health system. The sites of racism identified in this study can be targeted separately or simultaneously. Literature suggests to raise awareness of institutional racism and improve racial climate is likely to enhance any anti-racism mobilisation (Barnes-Josiah & Fitzgerald, 2004).

To address the sites of racism identified within this study, it is necessary to review decision-making practices within the health sector, from board to senior management level, to the operational context of policy making. There are a multiplicity of techniques to enable minority views and indigenous perspectives to be respected within decision making. Māori traditionally used variations of consensus decision making (Buck, 1950), which included the option of strategic withdrawal to allow parties to regroup and then re-engage after further reflection. The United Nations (2004) has commissioned work to explore the notion of deliberate democracy, which incorporates both consensus and majoritarian decision making as a way of protecting and enhancing indigenous voice. Given the treaty relationship between Māori and the Crown, other power sharing models might be appropriate to strengthen Māori input into decision making within a New Zealand context. Joint co-management arrangements, for instance, have been trialled to manage natural resources with some success (Taiepa et al., 1997).

The relentless routine use of western bio-medical paradigms in the framing and content of health policy often serves to freeze out indigenous knowledge's and deny the well-established link between culture and health (National Advisory Committee on Health and Disability, 1998). This mono-culturalism can be addressed by recognising the validity of indigenous knowledge, incorporating indigenous world views and including evidence generated by indigenous academics. There are practical positive examples of this with Te Tai Tokerau Strategic Public Health Plan (Te Tai Tokerau MAPO Trust & Northland DHB, 2008), which utilises epidemiological analysis; kaupapa Māori evidence and community aspirations to inform policy. When conducting research, indigenous people can be oversampled to enable statistically valid quantitative analysis (Kalton, 2009). Crown officials need to be alert to whether international studies incorporate indigenous perspectives and can usefully provide insight to what works for Māori. If relevant research about what works for Māori does not exist it needs to be commissioned.

Deficiencies in cultural and political competencies are a function of recruitment strategies and the lack of relevant professional standards and professional development opportunities. To develop inclusive health policy, Crown officials need to be proficient in understanding Te Ao Māori (the Māori world) and western epistemological traditions of health and policy making. These limitations could be addressed through a tiered response. Firstly, tighten up recruitment selection criteria and recruitment processes. Secondly, relevant professional development opportunities need to be made available for existing staff to strengthen and support their practice, such as cultural competency programmes offered by Mauri Ora Associates (Ministry of Health, 2012). Thirdly, cultural and political competencies standards need to be introduced within the public service to ensure Crown officials are equipped to produce inclusive policy. Within the public health sector, practitioners have been expected to

demonstrate proficiency in these areas for some time (Health Promotion Forum, 2011; Public Health Association, 2007); it is timely that those overseeing policy and funding are also held accountable.

Despite a range of Crown consultation guidelines this study exposed problems in relation to the scope and implementation of consultation processes. At the heart of effective engagement with Māori is a commitment to whanaungatanga; that is the active and ongoing process of relationship building. Strong relationships enable the respectful exchange of information and underpin any successful collaboration. In the context of consultation in New Zealand, Māori are not one of many stakeholders they are Treaty partners to the Crown and need to be engaged with accordingly (O'Sullivan, 2008). Māori health providers have often been mandated by iwi or hapū to manage their interests in terms of health services. The Crown therefore needs to consider engaging through Māori provider leadership to allow senior management the autonomy to decide how their organisation will engage. Given the multiplicity of demands on Māori and the opportunity cost of participation in consultation where practical Māori could be compensated for their rare expertise.

As described by Berghan, Crown filters are Crown controlled, decision-making processes which serve to dilute Māori content within policy. The impact of these filters can be alleviated by the consistent application of a range of pre-existing equity and cultural tools (Cunningham, 1995; Ministry of Health, 2004, 2007). These tools have been commissioned by Crown agencies as mechanisms to ensure policy enhances equity, is culturally responsive and reduces health inequities. These tools need to be applied iteratively throughout policy development whenever there are substantive changes to the policy, rather than just once in the early developmental stages. It also seems clear that inclusive policy is more likely to be developed when Māori are involved in conception, development, implementation and evaluation.

Conclusion

It is our responsibility to ensure that our grandchildren and their children will enjoy good health and long lives. As citizens of the world, it is their rightful legacy. But if that legacy is to be fully realised we are going to have to make some changes (Te Rōpū Kai Hapai o Hauora o Te Tai Tokerau, 2008, viii).

This study describes patterns of institutional racism through a particular time period as seen by counter narratives. As racial climates shifts and change, it is reasonable to expect that how institutional racism manifests will also change, making this study a snapshot of a particular point in history. Given the global nature of colonisation, it seems likely that elements of the description of racism against indigenous people within this study may resonate within other colonial contexts. However, due to the geographic specificity of racism and the localized nature of this study, this claim remains unproven. The introduction of the whānau ora policy platform partway through this study did suggest something of a change of direction by the National-led coalition government towards a more inclusive policy direction.

History shows us that institutional racism can be transformed as in the example of the apartheid regime in South Africa. Change is often brought about by the organised efforts of civil society. Within the New Zealand public health sector there is a stated commitment to social justice, Te Tiriti o Waitangi and reducing health inequities, which is reinforced in competency documents and ethical guidelines and variously appears in legislation that underpins the sector. This study provides evidence of patterns of systemic institutional racism

within public health policy, which may also be present within other colonial health systems. The challenge for the public health sector in New Zealand is now to mobilize and take action to address this racism and privilege using our collective resources to uphold stated public health values. Inaction and silence from the public health sector and civil society generally, serves only to perpetuate a (modifiable) racist system.

References

- Barnes-Josiah, D., & Fitzgerald, M. (2004). *Undoing racism in public health: A blueprint for action in urban maternal and child health*. Omaha, NE: CityMatCH at the University of Nebraska Medical Centre.
- Berridge, D., Cowan, L., Cumberland, T., Davys, A., McDowell, H., Morgan, J., et al. (1984). *Institutional racism in the Department of Social Welfare*. Auckland, New Zealand: Department of Social Welfare.
- Bishop, R. (1996). *Whakawhanaungatanga: Collaborative research stories*. Palmerston North, New Zealand: Dunmore Press.
- Bishop, R. (2003). Changing power relations in education: Kaupapa Maori messages for 'mainstream' education in Aotearoa/New Zealand. *Comparative Education*, 39, 221-238.
- Borell, B., Gregory, A., McCreanor, T., Jensen, V., & Moewaka Barnes, H. (2009). "It's hard at the top but it's a whole lot easier than being at the bottom": The role of privilege in understanding disparities in Aotearoa/New Zealand. *Race/Ethnicity*, 3, 29-50.
- Buck, P. (1950). *The coming of the Maori*. Wellington, New Zealand: Maori Purposes Fund Board.
- Came. (2013). *Institutional racism and the dynamics of privilege in public health*. Germany: Lambert Publishing.
- Came. (2013). Beginning to address institutional racism within the public health sector: Insights from a provider survey. *Keeping up to date*, 38, 1-9.
- Came. (2013). Doing research in Aotearoa: A Pākehā exemplar of applying Te Ara Tika ethical framework. *Kotuitui*, 8(1), 1-10. doi: 10.1080/1177083x.2013.841265
- Came & da Silva, S. (2011). Building political competencies for the transformation of racism in Aotearoa. *Kotuitui*, 6, 113-123.
- Carroll, P., Blewden, M., & Witten, K. (2008). *Building research capacity in the social sciences* (BRCSS). Auckland, New Zealand: SHORE.
- Cunningham, C. (1995). He taura tieke: Measuring effective health services for Maori. Wellington, New Zealand: Ministry of Health.
- Department of Health (1984, March). *Proceedings of the hui whakaoranga: Maori health planning workshop*. Auckland, New Zealand: Author.
- Dowden, A., & Taite, S. (2001). *Aukati kaupapa 2000 evaluation report*. Wellington, New Zealand: BRC Marketing and Social Research.
- Durie, M. (1995, February) "Characteristics of Māori health research" *Hui Whakapiripiri*, Health Research Council Hongoeka Marae.
- Durie, M. (2005). Indigenous knowledge within a global knowledge system. *Higher Education Policy*, 18, 301-312.
- Durie, M. (1989). The Treaty of Waitangi and healthcare. *New Zealand Medical Journal* pp. 283-285.
- Durie, M. (1994). *Whaiora: Māori health development*. Auckland, New Zealand: Oxford University Press.
- Durie, M. (2001, November). *Cultural competence and medical practice in New Zealand*. Australia and New Zealand Boards and Council Conference. Wellington, New Zealand.
- Dyall, L. (1994). The pathway forward: Directions for Māori health: views of the hui te ara whakamua: Māori health decade hui Rotorua, 22-25 March 1994. *Social Policy Journal of New Zealand*, 2.
- Ford, C., & Airhihenbuwa, C. (2010). Critical race theory, race equity, and public health: Towards antiracism praxis. *American Journal of Public Health*, 100(S1), S30-S35. doi: 10.2105/AJPH.2009.171058

- Gauld, R. (2009). *Revolving doors: New Zealand's health reforms: The continuing saga* (2nd ed.). Wellington, New Zealand: Health Services Research Centre, Institute of Policy Studies.
- Gauld, R. (2003). One country, four systems: Comparing changing health policies in New Zealand. *International Political Science Review*, 24(2), 199-218.
- Gillborn, D. (2006). Critical race theory and education: Racism and anti-racism in educational theory and praxis. *Discourses: Studies in the Cultural Politics of Education*, 27, 11-32.
- Gluckman, P. (2011). *Towards better use of evidence in policy formation: A discussion paper*. Wellington, New Zealand: Office of the Prime Minister's Science Advisory Committee.
- Griffith, D., Mason, M., Yonas, M., Eng, E., Jefferies, V., Pliheik, S., & Parks, B. (2007). Dismantling institutional racism: Theory and action. *American Journal of Community Psychology*, 39, 381-392. doi: 10.1007/s10464-007-9117-0
- Health Promotion Forum (2011). *Ngā kaiakatanga hauora mō Aotearoa: Health promotion competencies for Aotearoa-New Zealand*. Auckland, New Zealand: Author.
- Hudson, M., Milne, M., Reynolds, P., Russell, K., & Smith, B. (2010). *Te ara tika guidelines for Māori research ethics: A framework for researchers and ethics committee members*. (p. 29). Wellington, New Zealand: Health Research Council.
- Humpage, L. (2005). Experimenting with a 'whole of government' approach: Indigenous capacity building in New Zealand and Australia. *Policy Studies*, 26(1), 47-66. doi: 10.1080/0144287500041744
- Huygens, I. (2011). Developing a decolonisation practice for settler colonisers: A case study from Aotearoa New Zealand. *Settler Colonial Studies*, 1, 53-81.
- Jackson, M. (1988). *The Māori and the criminal justice system: He whaipānga hou: A new perspective*. Wellington, New Zealand: Department of Justice.
- Jackson, M. (2000). *Steven Wallace: An analysis of the police report*. Retrieved from <http://www.converge.org.nz/pma/smoana.htm#abs>
- Jones, C. (2000). Levels of racism: A theoretical framework and a gardener's tale. *American Journal of Public Health*, 90, 1212-1215.
- Kalton, G. (2009). Methods of oversampling rare subpopulations in social surveys. *Survey Methodology*, 35, 125-141.
- King, A. (2000). *The New Zealand health strategy*. Wellington, New Zealand: Ministry of Health.
- King, A., & Turia, T. (2002). *He korowai oranga: Māori health strategy*. Wellington, New Zealand: Ministry of Health.
- Lange, R. (1999). *May the people live: a history of Maori health development 1900-1920*. Auckland, New Zealand: Auckland University Press.
- Mill, J. (2006/1859). *On liberty (Original work published 1859)*. London, England: Adamant.
- Ministerial Advisory Committee on a Māori Perspective on Social Welfare. (1988). *Puao te ata tu (Day break)*. Wellington, New Zealand: Department of Social Welfare.
- Ministerial Review Committee. (2009). *Meeting the challenge: Enhancing sustainability and the patient and consumer experience within the current legislative framework for health and disability services in New Zealand*. Wellington, New Zealand: Ministry of Health.
- Ministry of Health. (2002). *Consultation guidelines for the Ministry and District Health Boards relating to the provision of health and disability services*. Wellington, New Zealand: Author.
- Ministry of Health. (2003a). *Achieving health for all people: Whakatutuki te oranga hauora mo ngā tāngata katoa: A framework for public health action*. Wellington, New Zealand: Author.

- Ministry of Health. (2003b). *Improving quality: A systems approach for the New Zealand health and disability sector*. Wellington, New Zealand: Author.
- Ministry of Health. (2004). *A health equity assessment tool (equity lens) for tackling inequalities in health*. Wellington, New Zealand: Author.
- Ministry of Health. (2007). *Whānau ora health impact assessment*. Wellington, New Zealand: Author.
- Ministry of Health. (2011). *Māori smoking and tobacco use*. Wellington, New Zealand: Author.
- Ministry of Health. (2012). *Cultural competency training tool available*. Wellington, New Zealand: Author.
- Ministry of Health. (n.d.). *Public health service handbook: Service specifications*. Wellington, New Zealand: Author.
- Ministry of Social Development. (2010). *The social report 2010*. Wellington, New Zealand: Author.
- Moewaka Barnes, H. (2013). Better indigenous policies: An Aotearoa New Zealand perspective on the role of evaluation *Better indigenous policies: The role of evaluation: Roundtable proceedings* (pp. 155-181). Canberra, Australia: Productivity Commission.
- Moewaka Barnes, H. (2006). Transforming science: How our structures limit innovation. *Journal of Social Policy* (29), 1-16.
- National Advisory Committee on Health and Disability. (1998). *The social, cultural and economic determinants of health in New Zealand: Action to improve health*. Wellington, New Zealand: National Health Committee.
- Nunns, H. 2009, Responding to the demand for quicker evaluation findings, *Social Policy Journal of New Zealand*, vol. 34, pp. 89–99.
- O'Sullivan, D. (2007). *Beyond biculturalism: The politics of an indigenous minority*. Wellington, New Zealand: Huia
- O'Sullivan, D. (2008). The Treaty of Waitangi in contemporary New Zealand politics. *Australian Journal of Political Science*, 43(2), 317-331. doi: 10.1080/10361140502035804
- Palmer, G., & Palmer, M. (2004). *Bridled power: New Zealand's constitution and government* (4th ed.). Auckland, New Zealand: Oxford University Press.
- Paradies, Y. (2005). Anti-racism and indigenous Australians. *Analyses of Social Issues and Public Policy*, 5, 1-28.
- Pōmare, E. (1980). *Maori standards of health: A study of the 20 year period 1955-75: A report prepared for the Medical Research Council of New Zealand*. Wellington, New Zealand: Medical Research Council of New Zealand.
- Pōmare, E., Keefe-Ormsby, V., Ormsby, C., Pearce, N., Reid, P., Robson, B., et al. (1995). *Hauora: Māori standards of health 3: A study of the years 1970-1991*. Wellington, New Zealand: Te Rōpū Rangahau Māori Research Centre.
- Pomare, M. (1908). *Etahi kupu mo te ora*. Wellington, New Zealand: Hone Makae.
- Public Health Association. (2007). *Generic competencies for public health in Aotearoa-New Zealand*. Wellington, New Zealand: Ministry of Health.
- Public Health Association. (2012). *Te ture whakaruruhau: Code of ethical principles for public health in Aotearoa New Zealand*. Wellington, New Zealand: Author.
- Ramsden, I. (1994). A challenge to education. *Social Policy Journal of New Zealand*.
- Ratima, M. (2001). *Kia urūru mai a hauora: Being healthy, being Maori: Conceptualising Maori health promotion*. Dunedin, New Zealand: Otago University.

- Reid, P., & Robson, B. (2007). Understanding health inequities. In H.R. Robson B (Ed.), *Hauora Maori standards of health IV* pp. 3-11). Wellington, New Zealand: Te Rōpū Rangahau Hauora A Eru Pomare.
- Robson, B. (2007). Economic determinants of Maori health and disparities. In M. Bargh (Ed.), *Resistance: An indigenous response to neoliberalism* pp. 45-61). Wellington, New Zealand: Huia.
- Robson, B., & Harris, R. (2007). *Hauora: Maori standards of health 4. A study of the years 2000-2005*. Wellington, New Zealand: Te Rōpū Rangahau Hauora a Eru Pōmare.
- Ryall, T. (2007). *Better sooner more convenient: Health discussion paper*. Wellington, New Zealand: National Party.
- Signal, L., Martin, J., Reid, P., Carroll, C., Howden-Chapman, P., Ormsby, V., et al. (2007). Tackling health inequalities: Moving theory to action. *International Journal for Equity in Health*, 6.
- Smith, L. (1999). *Decolonizing methodologies: Research and indigenous peoples*. Dunedin, New Zealand: University of Otago Press.
- State Services Commission. (2007). *Standards of integrity and conduct*. Wellington, New Zealand: Author.
- State Services Commission. (2010). *Equality and diversity report: Diversity in the senior management of the public service*. Wellington, New Zealand: Author.
- Statistics New Zealand. (2013). *New Zealand period life tables: 2010-12*. Wellington, New Zealand: Author.
- Sudbury, J., & Okazawa-Rey, M. (Eds.). (2009). *Activist scholarship: Antiracism, feminism and social change*. London, England: Paradigm.
- Taiepa, T., Lyver, P., Horsely, P., Davis, J., Brag, M., & Moller, H. (1997). Co-management of New Zealand's conservation estate by Maori and Pakeha: A review. *Environmental Conservation*, 24, 236-250.
- Te Kingi, K. (2002). *Hua oranga best outcomes for Māori*, Unpublished doctoral thesis, Massey University, Palmerston North, New Zealand.
- Te Puni Kōkiri. (2000). *Māori provider views of government funding*. Wellington, New Zealand: Author.
- Te Rōpū Kai Hapai o Hauora o Te Tai Tokerau. (2008). *Te Tai Tokerau strategic Maori health plan 2008-2013*. Whangarei, New Zealand: Northland DHB.
- Te Tai Tokerau MAPO Trust, & Northland DHB. (2008). *Te Tai Tokerau strategic public health plan 2008-2011*. Whangarei, New Zealand: Northland DHB.
- Treasury. (2009). *Guidelines for contracting with non-governmental organisations for services sought by the Crown*. Wellington, New Zealand: Author.
- United Nations. (1948). *Universal declaration of human rights*. Geneva, Switzerland: Author.
- United Nations. (1976). *International covenant on economic, social and cultural rights*. Geneva, Switzerland: Author.
- United Nations. (2004). *Ideas and contributions: Democracy in Latin America*. New York, NY: Author.
- United Nations. (2007). *Declaration on the rights of indigenous peoples*. New York, NY: Author.
- Verba, S. (2006). Fairness, equality, and democracy: three big words. *Social Science: An International Quarterly of Social Sciences*, 73, 499-540.
- Waa, A. (2012). *Consolidating action on Māori tobacco control: A discussion paper on establishing a Māori resistance alliance*. Wellington, New Zealand: Te Reo Mārama.
- Whānau Ora Taskforce. (2009). *Whānau ora: A whānau-centred approach to Maori wellbeing*. Wellington, New Zealand: Ministry of Social Development.

Whānau Ora Taskforce. (2010). *Whānau ora: Report of the taskforce on whānau-centred initiatives*. Wellington, New Zealand: Minister for the Community and Voluntary Sector.

Wright, R. (2010, February 15). *Government vetos race restrictions on whanau ora scheme*. TV3.

